U.S. DEPARTMENT OF THE INTERIOR

Respirator Medical Evaluation Questionnaire

(Reflects OSHA's Mandatory Questionnaire in Appendix C to 29 CFR 1910.134)

To the employer: Employees who are to use a respirator in the course of their official duties are to have an annual medical evaluation. The evaluation must either include a physical examination by a licensed health professional, or completion of this form by the employee and its review by an agency health care professional (see "Medical Clearance for Respirator Use – Clinical Protocol" in the DOI Occupational Medicine Program Handbook). Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination. However, certain responses, or patterns of response, may lead the reviewer to request further information, or a medical examination, in order to reach a conclusion regarding the employee's ability to safely use a respirator.

To the employee: Can you read (select one): Yes ☐ No ☐

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date _____

2. Your name:_____

3. Your age (to nearest year):_____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title:_____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):

_____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (select one): Yes ☐ No ☐

11. Check the type of respirator you will use (you can check more than one category):

a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (select one): Yes ☐ No ☐

If ``yes,'' what type(s):_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please select ``yes'' or ``no'').

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes ☐ No ☐

2. Have you ever had any of the following conditions?
   a. Seizures (fits): Yes ☐ No ☐
   b. Diabetes (sugar disease): Yes ☐ No ☐
   c. Allergic reactions that interfere with your breathing: Yes ☐ No ☐
   d. Claustrophobia (fear of closed-in places): Yes ☐ No ☐
   e. Trouble smelling odors: Yes ☐ No ☐

3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis: Yes ☐ No ☐
   b. Asthma: Yes ☐ No ☐
   c. Chronic bronchitis: Yes ☐ No ☐
   d. Emphysema: Yes ☐ No ☐
   e. Pneumonia: Yes ☐ No ☐
   f. Tuberculosis: Yes ☐ No ☐
   g. Silicosis: Yes ☐ No ☐
   h. Pneumothorax (collapsed lung): Yes ☐ No ☐
   i. Lung cancer: Yes ☐ No ☐
   j. Broken ribs: Yes ☐ No ☐
   k. Any chest injuries or surgeries: Yes ☐ No ☐
   l. Any other lung problem that you've been told about: Yes ☐ No ☐

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: Yes ☐ No ☐
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes ☐ No ☐
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes ☐ No ☐
   d. Have to stop for breath when walking at your own pace on level ground: Yes ☐ No ☐
   e. Shortness of breath when washing or dressing yourself: Yes ☐ No ☐
   f. Shortness of breath that interferes with your job: Yes ☐ No ☐
   g. Coughing that produces phlegm (thick sputum): Yes ☐ No ☐
   h. Coughing that wakes you early in the morning: Yes ☐ No ☐
   i. Coughing that occurs mostly when you are lying down: Yes ☐ No ☐
   j. Coughing up blood in the last month: Yes ☐ No ☐
   k. Wheezing: Yes ☐ No ☐
   l. Wheezing that interferes with your job: Yes ☐ No ☐
   m. Chest pain when you breathe deeply: Yes ☐ No ☐
   n. Any other symptoms that you think may be related to lung problems: Yes ☐ No ☐

5. Have you ever had any of the following cardiovascular or heart problems?
   a. Heart attack: Yes ☐ No ☐
   b. Stroke: Yes ☐ No ☐
   c. Angina: Yes ☐ No ☐
   d. Heart failure: Yes ☐ No ☐
   e. Swelling in your legs or feet (not caused by walking): Yes ☐ No ☐
   f. Heart arrhythmia (heart beating irregularly): Yes ☐ No ☐
   g. High blood pressure: Yes ☐ No ☐
   h. Any other heart problem that you've been told about: Yes ☐ No ☐

Employee Name:_____

6. Have you ever had any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: Yes ☐ No ☐
b. Pain or tightness in your chest during physical activity: Yes ☐ No ☐
c. Pain or tightness in your chest that interferes with your job: Yes ☐ No ☐
d. In the past two years, have you noticed your heart skipping or missing a beat: Yes ☐ No ☐
e. Heartburn or indigestion that is not related to eating: Yes ☐ No ☐
f. Any other symptoms that you think may be related to heart or circulation problems: Yes ☐ No ☐

7. Do you currently take medication for any of the following problems?

a. Breathing or lung problems:
b. Heart trouble: Yes ☐ No ☐
c. Blood pressure: Yes ☐ No ☐
d. Seizures (fits): Yes ☐ No ☐

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes ☐ No ☐
b. Skin allergies or rashes: Yes ☐ No ☐
c. Anxiety: Yes ☐ No ☐
d. General weakness or fatigue: Yes ☐ No ☐
e. Any other problem that interferes with your use of a respirator: Yes ☐ No ☐

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes ☐ No ☐

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently): Yes ☐ No ☐

11. Do you currently have any of the following vision problems?

a. Wear contact lenses: Yes ☐ No ☐
b. Wear glasses: Yes ☐ No ☐
c. Color blind: Yes ☐ No ☐
e. Any other eye or vision problem: Yes ☐ No ☐

12. Have you ever had an injury to your ears, including a broken ear drum: Yes ☐ No ☐

13. Do you currently have any of the following hearing problems?

a. Difficulty hearing: Yes ☐ No ☐
b. Wear a hearing aid: Yes ☐ No ☐
c. Any other hearing or ear problem: Yes ☐ No ☐

14. Have you ever had a back injury: Yes ☐ No ☐

15. Do you currently have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes ☐ No ☐
b. Back pain: Yes ☐ No ☐
c. Difficulty fully moving your arms and legs: Yes ☐ No ☐
d. Pain or stiffness when you lean forward or backward at the waist: Yes ☐ No ☐
e. Difficulty fully moving your head up or down: Yes ☐ No ☐
f. Difficulty fully moving your head side to side: Yes ☐ No ☐
g. Difficulty bending at your knees: Yes ☐ No ☐
h. Difficulty squatting to the ground: Yes ☐ No ☐
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes ☐ No ☐

Employee Name:_____

j. Any other muscle or skeletal problem that interferes with using a respirator: Yes ☐ No ☐

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes ☐ No ☐

If ``yes,'' do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes ☐ No ☐

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes ☐ No ☐

If ``yes,'' name the chemicals if you know them:_____

_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes ☐ No ☐
b. Silica (e.g., in sandblasting): Yes ☐ No ☐
c. Tungsten/cobalt (e.g., grinding or welding this material): Yes ☐ No ☐
d. Beryllium: Yes ☐ No ☐
e. Aluminum: Yes ☐ No ☐
f. Coal (for example, mining): Yes ☐ No ☐
g. Iron: Yes ☐ No ☐
h. Tin: Yes ☐ No ☐
i. Dusty environments: Yes ☐ No ☐
j. Any other hazardous exposures: Yes ☐ No ☐

If ``yes,'' describe these exposures:_____

_____

4. List your current and previous hobbies:_____

_____

5. Have you been in the military services? Yes ☐ No ☐

If ``yes,'' were you exposed to biological or chemical agents (either in training or combat): Yes ☐ No ☐

6. Have you ever worked on a HAZMAT team? Yes ☐ No ☐

7. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes ☐ No ☐

If ``yes,'' name the medications if you know them:_____

_____

Deliver this form to the examiner or reviewer to complete the Summary and Recommendations sheet.

Employee Name:_____

Department of the Interior

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE SUMMARY AND RECOMMENDATIONS

To Be Completed By The Examiner / Reviewer:

Employee Name:_____

(select one box and provide comments as appropriate)

This employee has been found to be physically able to use the following (check** each* [ ] *that **applies):

[ ] Single use, filter mask (four attachment points)
[ ] Half-faced cartridge-type, negative pressure
[ ] Full-faced cartridge-type respirator, negative pressure
[ ] Half-faced powered cartridge-type (PAPR)
[ ] Full-faced powered cartridge-type (PAPR)
[ ] Self-contained breathing apparatus (SCBA)
[ ] Hood/helmet powered cartridge-type (PAPR)
[ ] Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)
[ ] Other (describe)_____

When wearing a respirator, the employee has been informed to limit his/her activity level* to the following: (check one [ ])
[ ] Mild Exertion
[ ] Moderate Exertion
[ ] Heavy Exertion (No specified limitations)

Other limitations needed (if any) when wearing a respirator:

_____

_____

This respirator clearance expires 1 2 3 years from the date below. (*If not marked, clearance expires in 1 year*) (*circle one*)

This employee has been found to be physically NOT able to use a respirator

ð ***There is insufficient information to make a determination at this time***

The following additional tests, or medical information, will be required in order to make a determination regarding the safe use of a respirator by this employee:

_____

_____

_____
Reviewer's Name (Print)

_____ _____
Reviewer's Signature **Date**

Return this completed summary sheet to the agency supervisor or other designate agency official, separate from the completed questionnaire. The questionnaire is to be filed and maintained in a confidential and secure manner.

* Light/Mild exertion (2-3 METS)= negligible lifting, extended walking (flat surface), extended standing, writing
Moderate exertion (4-5 METS) = lifting 10lbs (5 or more lifts/min), fast walking (4mph), gardening/digging, pushing, pulling
Heavy exertion (5-10 METS) = jogging (10 minute mile), chopping wood, climbing hills, life-saving activities, firefighting,